DIVISION OF HEALTH CARE FINANCE AND POLICY

114.6 CMR 11.00: ADMINISTRATION OF THE UNCOMPENSATED CARE POOL

11.01 General Provisions

(1) Scope, Purpose and Effective Date. 114.6 CMR 11.00 governs the procedures effective October 1, 2006, for administering the Uncompensated Care Pool, including payments to acute hospitals and community health centers and payments from acute hospitals and surcharge payers.

(2) Authority: 114.6 CMR 11.00 is adopted pursuant to M.G.L. c. 118G and Chapter 58 of the Acts of 2006.

11.02 Definitions

Meaning of Terms: As used in 114.6 CMR 11.00, unless the context otherwise requires, terms have the following meanings. All defined terms in 114.6 CMR 11.00 are capitalized.

Actual Acquisition Cost (AAC). The amount a pharmacy pays for a drug, net of discounts, rebates, charge backs, and other adjustments to the price of the drug.

Ambulatory Surgical Center. Any distinct entity that operates exclusively for the purpose of providing surgical services to patients not requiring Hospitalization and meets the Health Care Financing Administration requirements for participation in the Medicare program.

Ambulatory Surgical Center Services. Services described for purposes of the Medicare program pursuant to 42 USC s.1395k(a)(2)(F)(I). These services include only facility services and do not include physician fees.

Charge. The uniform price for a specific service charged by a Hospital or Community Health Center.

Community Health Center. A clinic that provides comprehensive ambulatory services and that (a) is licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s.51; (b) meets the qualifications for certification (or provisional certification) by the Division of Medical Assistance and enters into a provider agreement pursuant to 130 CMR 405.000; (c) operates in conformance with the requirements of 42 U.S.C. s254(c); and (d) files cost reports as requested by the Division.

Community Health Center 340B Pharmacy. A Community Health Center eligible to purchase discounted drugs through a program established by Section 340B of Public Health law 102-585, the Veterans Health Act of 1992, permitting certain grantees of federal agencies access to reduced cost drugs for their patients, and is registered and listed as the 340B Pharmacy within the United States Department of Health and Human Services, Office of Pharmacy Affairs (OPA) database. 340B Pharmacy services may be provided at on-site or off-site locations.

Cost to Charge Ratio. A percentage used to reduce Uncompensated Care Charges to costs, calculated pursuant to 114.6 CMR 11.04(3).

Critical Access Services. Medically necessary Hospital Services, as defined in 114.6 CMR 12.00, that include inpatient services, certain outpatient services, and services provided in a hospital-licensed facility located off the hospital campus that is a Hospital Licensed Health Center, a school-based health center, or other satellite location. Critical access services to not include on-campus outpatient clinic visits for non-emergent or non-urgent Primary Care unless: (1) there is no Community or Hospital Licensed Health Center providing both adult and pediatric Primary Care within 5 miles driving distance of the hospital campus as determined by the Division; or (2) the patient's medical condition is so severe or complex that his/her primary care cannot be adequately provided in a community setting. The Division publishes a list of hospitals exempt from the Critical Access provision because there is no community health center within 5 miles driving distance.

Disproportionate Share Hospital. A Hospital that serves a disproportionate share of low income patients and that meets the criteria set forth in 114.1 CMR 36.04.

Division. The Division of Health Care Finance and Policy established under M.G.L. c. 118G or its designated agent.

Eligible Services. Services eligible for payment from the Uncompensated Care Trust Fund pursuant to 114.6 CMR 12.00, including Services to Low Income Patients under 114.6 CMR 12.03, Medical Hardship Services under 114.6 CMR 12.05, and Emergency Bad Debt under 114.6 CMR 12.04.

Emergency Bad Debt. The amount of uncollectible debt for emergency services that meets the criteria set forth in 114.6 CMR 12.04.

Fiscal Year. The time period of 12 months beginning on October 1 of any calendar year and ending on September 30 of the following calendar year.

Free Care. Unpaid Hospital or Community Health Center Charges for services that meet the criteria set forth in 114.6 CMR 12.00 and M.G.L. c. 118G.

Governmental Unit. The commonwealth, any department, agency board, or commission of the Commonwealth, and any political subdivision of the commonwealth.

Gross Patient Service Revenue. The total dollar amount of a Hospital's Charges for patient care services rendered in a Fiscal Year.

Guarantor. A person or group of persons who assumes the responsibility of payment for all or part of a Hospital's or Community Health Center's Charge for services.

Hospital. An acute Hospital licensed under M.G.L. c. 111, s. 51 that contains a majority of medical-surgical, pediatric, obstetric and maternity beds, as defined by the Department of Public Health.

Hospital Licensed Health Center. A facility that is not physically attached to the hospital, or located on or proximate to the Hospital campus, that: (a) operates under the hospital's license; (2) meets MassHealth requirements for reimbursement as a Hospital Licensed Health Center under 130 CMR 410.413; (3) is approved by and enrolled with the MassHealth Enrollment Unit as a Hospital Licensed Health Center; (4) possesses a distinct Hospital Licensed Health Center MassHealth provider number; (5) is subject to the fiscal, administrative and clinical management of the hospital; and (6) provides services solely on an outpatient basis.

Indirect Payment. A payment made by an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I to a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, that then forward the payment to member Hospitals or Ambulatory Surgical Centers; or a payment made to an individual to reimburse him or her for a payment made to a Hospital or Ambulatory Surgical Center.

Individual Dental Visit. A face-to-face meeting between a patient and a dentist within the Community Health Center setting, for purposes of examination, diagnosis, or treatment.

Individual Medical Visit. A face-to-face meeting between a patient and a physician, physician assistant, nurse practitioner, nurse midwife, clinical psychologist, or licensed social worker within the Community Health Center setting, for purposes of examination, diagnosis, or treatment.

Individual Payer. A patient or Guarantor who pays his or her own Hospital or Ambulatory Surgical Center bill and is not eligible for reimbursement from an insurer or other source.

Institutional Payer. A Surcharge Payer that is an entity other than an Individual Payer.

Low Income Patient. A patient that meets the criteria in 114.6 CMR 12.03(3).

Medical Hardship. Services provided to patients that meet the criteria in 114.6 CMR 12.05.

Medicare Program. The medical insurance program established by Title XVIII of the Social Security Act.

Office of Pharmacy Affairs (OPA). The Office of Pharmacy Affairs, and any successor agencies, is a division within the United States Department of Health and Human Services that monitors the registration of 340B pharmacies.

Patient. An individual who receives or has received medically necessary services at a Hospital or Community Health Center.

Payment. A check, draft or other paper instrument, an electronic fund transfer, or any order, instruction, or authorization to a financial institution to debit one account and credit another.

Pharmacy and Therapeutics (P&T) Committee. An advisory group to the medical staff and serves as the organizational line of communication between the medical staff and the pharmacy

department. The group is composed of physicians, pharmacists, and other health professionals selected with the guidance of the medical staff to recommend policy to the medical staff and administration on matters related to the therapeutic use of drugs.

Pool. The Uncompensated Care Pool established pursuant to M.G.L. c.118G, s.18.

Private Sector Charges. GPSR attributable to all patients less GPSR attributable to Titles XVIII, XIX, and XXI, other publicly aided patients, free care and bad debt. For each Pool Fiscal Year, a Hospital's Private Sector Charges are determined using data reported in the RSC-403 for that Pool Fiscal Year.

Provider. A Hospital, including hospital-licensed off-campus entities, or Community Health Center that provides and submits claims for Eligible Services.

Public Service Hospital. A public Hospital or an acute Hospital operating pursuant to St. 1995, c. 147, with a private sector payer mix of less than 35% of its GPSR and with Uncompensated Care charges of more than 20% of its GPSR.

Publicly Aided Patient. A person who receives Hospital or Community Health Center care and services for which a Governmental Unit is liable in whole or in part under a statutory obligation.

Registered Payer List. A list of Institutional Payers as defined in 114.6 CMR 11.06(3)(b).

Shortfall Amount. In a fiscal year, the positive difference between the sum of Allowable Uncompensated Care Costs for all Hospitals and the revenue available for distribution to Hospitals.

Sole Community Hospital. Any acute Hospital classified as a Sole Community Hospital by the U.S. Health Care Financing Administration's Medicare regulations, or any Hospital that demonstrates to the Division's satisfaction that it is located more than 25 miles from other acute Hospitals in the Commonwealth and that it provides services for at least 60% of its primary service area.

Specialty Hospital. An acute Hospital qualifying as exempt from the Medicare prospective payment system regulations or any acute Hospital that limits its admissions to patients under active diagnosis and treatment of eyes, ears, nose and throat or to children or patients under obstetrical care.

Surcharge Payer. An individual or entity that (a) makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; and (b) meets the criteria set forth in 114.6 CMR 11.06(1)(a).

Surcharge Percentage. The percentage assessed on certain payments to Hospitals and Ambulatory Surgical Centers determined pursuant to 114.6 CMR 11.06(2).

Third Party Administrator. An entity that administers payments for health care services on behalf of a client plan in exchange for an administrative fee. A Third Party Administrator may provide client services for a self-insured plan or an insurance carrier's plan. Third Party Administrators will be deemed to use a client plan's funds to pay for health care services whether the Third Party Administrator pays providers with funds from a client plan, with funds advanced by the Third

Party Administrator subject to reimbursement by the client plan, or with funds deposited with the Third Party Administrator by a client plan.

UC Form. The form on which hospitals reported monthly free care and emergency room bad debt write offs to the Division through FY 2006.

Uncompensated Care. The sum of reported net Free Care and Emergency Bad Debt.

11.03 Reporting Requirements

(1) General. Each Provider, Surcharge Payer and Ambulatory Surgical Center shall file or make available information that is required or that the Division deems reasonably necessary for implementation of 114.6 CMR 11.00.

(a) Eligible Services Claims Data

1. Providers must submit electronic medical claims information for all Eligible Services. Providers must complete and submit claims, and resubmit failed claims, in accordance with Division specifications and 114.6 CMR 12.00.

2. The Division may revise the data specifications, the data collection scheduled, or other administrative requirements from time to time by administrative bulletin.

(b) Patient Level Data. Providers must make patient level data available to the Division, upon request, for patients for whom they have submitted a claim for Eligible Services. These patient level data include but are not limited to cost data, patient diagnoses and types of Eligible Services provided, patient demographics, write-off amounts, unique patient identifiers, and other such data that enable the Division to conduct analyses, verify eligibility, and calculate settlements on a case-by-case basis.

(c) Audit. The Division may audit data submitted under 114.6 CMR 11.03 to ensure accuracy. The Division may adjust reported Uncompensated Care to reflect audit findings. Providers must maintain records sufficient to document compliance with all screening and documentation requirements of 114.6 CMR 12.00.

(3) Hospitals

(a) Each Hospital claim for Eligible Services must contain a site-specific Identification Number as assigned by the Division. The Division will assign individual Identification Numbers to each Hospital, Hospital Licensed Health Centers, satellite clinics, and other off-campus locations that provide Eligible Services.

(b) The Division may require Hospitals to submit interim data on revenues and costs to monitor compliance with federal Upper Limit and Disproportionate Share payment limits. Such data may include, but not be limited to, Gross and Net Patient Service Revenue for Medicaid non-managed care, Medicaid managed care, and all payers combined; and total patient service expenses for all payers combined.

(c) Surcharge Payment Data.

1. Unmatched Payer Report. Each Hospital must submit an Unmatched Payer Report to the Division every four months, in accordance with a schedule specified by the Division. The Hospital must report the total

amount of payments for services received from each Institutional Payer that does not appear on the Registered Payer List. The hospital must report these data in an electronic format specified by the Division.

2. Quarterly Report for Private Sector Payments. Each Hospital must report total payments made by the largest Institutional Surcharge Payers. The Division will specify: the Institutional payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Division may modify the reporting requirements from time to time by administrative bulletin.

(e) Penalties. The Division may deny payment for Eligible Services to any Hospital that fails to comply with the reporting requirements of 114.6 CMR 11.00 or 114.6 CMR 12.00 until such Hospital complies with the requirements. The Division will notify such Hospital of its intention to withhold reimbursement.

(3) Community Health Centers

(a) Low Income Patient Payment Voucher. Each Community Health Center must submit a monthly payment voucher detailing the center's Individual Medical Visits provided to Low Income or Medical Hardship Patients within 45 days after the last day of the designated reporting period.

(b) Each Community Health Center must, upon request, provide the Division with patient account records and related reports as set forth in 114.6 CMR 11.03(1)(b).

(c) Electronic Data Submission. Each Community Health Center must submit claims for Eligible Services data to the Division in accordance with the requirements of 114.6 CMR 11.03(6) and the data specification requirements of the Division.

(d) Penalties. The Division may deny payments for Eligible Services to any Community Health Center that fails to comply with the reporting requirements of 114.6 CMR 11.00 or 114.6 CMR 12.00 until such Community Health Center complies with the requirements. The Division will notify Community Health Centers of its intention to withhold reimbursement.

(4) Surcharge Payers.

(a) Monthly Surcharge Payment Report. The Division may require that an Institutional Payer submit monthly reports of payments to Hospitals and Ambulatory Surgical Centers.

(b) Third Party Administrators.

1. A Third Party Administrator Surcharge Payer that makes payments to Hospitals and Ambulatory Surgical Centers on behalf of one or more insurance carriers must file an annual report with the Division. The report shall include the name of each insurance carrier for which it makes surcharge payments. The Division may also specify additional reporting requirements concerning payments made on behalf of self insured plans. Reports shall be in an electronic format specified by the Division.

2. Third Party Administrators must submit annual reports by July 1 of each year for the time period defined by the Division.

(c) Penalties. Any Surcharge Payer that fails to file data, statistics, schedules, or other information pursuant to 114.6 CMR 11.03 or which falsifies same, shall be subject to a civil penalty of not more than $5000 for each day on which such

violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.6 CMR 11.00.

(5) Ambulatory Surgical Centers

(a) Unmatched Payer Report. Each Ambulatory Surgical Center must submit an unmatched payer report to the Division every four months, in accordance with a schedule specified by the Division. The Ambulatory Surgical Center must report the total amount of payments for services received from each Institutional Surcharge Payer that does not appear on the Registered Payer List.
(b) Quarterly Report for Private Sector Payments. Each Ambulatory Surgical Center must report total payments made by the largest Institutional Surcharge Payers. The Division will specify the Institutional Payers for which reporting is required, the periods for which reporting is required, and the reporting format. The Division may modify the reporting requirements from time to time by administrative bulletin.
(c) Penalties. An Ambulatory Surgical Center that knowingly fails to file with the Division any data required by 114.6 CMR 11.03 or knowingly falsifies the same shall be subject to a $500.00 fine.

11.04 Sources and Uses of Funds

(1) Revenue Available for Payments to Hospitals.

(a) 1. Available revenue for each Fiscal Year consists of:

a. revenue produced by Hospital assessments and the Surcharge on Hospital payments;

b. supplemental funding consisting of Compliance Liability Revenue and other designated revenue; and

c. state appropriations of federal financial participation funds and any other available appropriations.

2. Available revenue is reduced by:

a. payments to Community Health Centers;

b. amounts withheld as reserves for contingencies;

c. expenses for administration of the Pool authorized by M.G.L. c. 118G;

d. funding for designated demonstration projects;

e. expenses for managed care contracts or interagency service agreements as authorized by M.G.L. c. 118G, s.18(j); and

f. any other expenditures authorized by the General Court**.**

(b) Revenue Available in FY 2007. For FY 2007, total revenue available for payments from the Uncompensated Care Trust Fund is $610,000,000. Available revenue consists of:

1. $160,000,000 of hospital assessments determined pursuant to 114.6 CMR 11.05;

2. $160,000,000 of surcharge payments as set forth in 114.6 CMR 11.06; and

3. $290,000,000 transferred from the Commonwealth Care Trust Fund pursuant to Chapter 58 of the Acts of 2006.

(2) Payments from the Uncompensated Care Trust Fund. In FY 2007, payments from the Uncompensated Care Trust Fund are authorized as follows:

(a) up to $550,000,000 for payments to Hospitals, of which $70,000,000 will be used to reimburse uncompensated care costs at the two Disproportionate Share hospitals with the highest relative volume of free care costs for hospital year 2007;

(b) up to $56,000,000 for payments to Community Health Centers;

(c) up to $4,000,000 for administration, including Demonstration Projects required to be funded pursuant to §§ 156 to 158 of Chapter 184 of the Acts of 2002.

(3) FY 2007 Payments may be increased if there is a shortfall in funding and additional funding becomes available.

11.05 Total Hospital Assessment Liability to the Pool

A Hospital's gross liability to the Uncompensated Care pool is the product of (a) the ratio of its Private Sector Charges to all Hospitals' Private Sector Charges and (b) total Hospital liability to the Uncompensated Care pool as determined by the General Court for each Fiscal Year. In FY 2007, total Hospital Liability is $160,000,000.

11.06 Surcharge on Hospital Payments

(1) General. There is a surcharge on certain payments to Hospitals and Ambulatory Surgical Centers. The surcharge amount equals the product of (a) payments subject to surcharge as defined in 114.6 CMR 11.06(1)(b) and (b) the Surcharge Percentage as defined in 114.6 CMR 11.06(2).

(a) Surcharge Payer.

1. A Surcharge Payer is an individual or entity that makes payments for the purchase of health care Hospital Services and Ambulatory Surgical Center Services; provided, however, that the term "surcharge payer" shall not include (1) Title XVIII and Title XIX programs and their beneficiaries or recipients; (2) other governmental programs of public assistance and their beneficiaries or recipients; and (3) the workers compensation program established pursuant to M.G.L. c.152.

2. The same entity that pays that Hospital or ambulatory surgical center for services must pay the surcharge. If an entity such as a Third Party Administrator acts on behalf of a client plan and uses the client plan's funds to pay for the services, or advances funds to pay for the services for which it is reimbursed by the client plan, it must also act on behalf of the client plan and use the client plan's funds to pay the surcharge or advance funds to pay the surcharge for which it will be reimbursed by the client plan.

(b) Payments subject to surcharge. Payments subject to surcharge include:

1. direct and Indirect Payments made by Surcharge Payers on or after January 1, 1998, regardless of the date services were provided, to:(1) Massachusetts acute hospitals for the purchase of acute Hospital Services; and (2) Massachusetts Ambulatory Surgical Centers for the purchase of Ambulatory Surgical Center Services.

2. payments made by national health insurance plans operated by foreign governments; and payments made by an embassy on behalf of a foreign national not employed by the embassy.

(c) Payments not subject to surcharge. Payments not subject to surcharge include:

1. payments, settlements and judgments arising out of third party liability claims for bodily injury that are paid under the terms of property or casualty insurance policies;
2. payments made on behalf of Medicaid recipients, Medicare beneficiaries, or persons enrolled in policies issued pursuant to chapter 176K or similar policies issued on a group basis;
3. payments made by a Hospital to a second Hospital for services that the first Hospital billed to a Surcharge Payer;
4. payments made by a group of providers, including one or more Massachusetts acute care Hospitals or Ambulatory Surgical Centers, to member Hospitals or Ambulatory Surgical Centers for services that the group billed to an entity licensed or approved under M.G.L. c.175, c.176A, c.176B, c.176G, or c.176I;
5. payments made on behalf of an individual covered under the Federal Employees Health Benefits Act at 5 U.S.C. 8901 et seq.;
6. payments made on behalf of an individual covered under the workers compensation program under M.G.L. c. 152; and
7. payments made on behalf of foreign embassy personnel who hold a Tax Exemption Card issued by the United States Department of State.

(d) The surcharge shall be distinct from any other amount paid by a Surcharge Payer for the services provided by a Hospital or Ambulatory Surgical Center. Surcharge amounts paid shall be deposited in the Uncompensated Care Pool.

(2) Calculation of the Surcharge Percentage. The Division will use the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to Hospitals and Ambulatory Surgical Centers, established in M.G.L. c.118G, s.18A. The Division will establish the Surcharge Percentage effective October 1, 2003 and each successive year before September 1 of each year, as follows:

(a) The Division will determine the total amount to be collected by adjusting $160,000,000 for any over or under collections from Institutional Payers and individuals in previous years, including audit adjustments, as well as any over or under collections projected for October or November of the coming year.
(b) The Division will project annual aggregate payments subject to the surcharge based on historical data, with any adjustments the Division deems necessary.
(c) The Division will divide the amount determined in 114.6 CMR 11.06(2)(a) by the amount determined in 114.6 CMR 11.06(2)(b).

(3) Payer Registration.

(a) Except for non-United States national insurers that have made less than ten payments per year in the prior three years to Massachusetts Hospitals and/or Ambulatory Surgical Centers, all Institutional Payers must register with the Division by completing and submitting the Uncompensated Care Pool Surcharge Payer Registration form. Institutional Payers must register only once. These payers shall submit the Registration form to the Division before December 10,

1997 for Pool Fiscal Year 1998; or within 30 days after making a payment to any Massachusetts Hospital or Ambulatory Surgical Center.

(b) Registered Payer List. The Division will compile lists of registered Institutional Payers, and will update the lists quarterly. The Division will distribute these lists to Hospitals and Ambulatory Surgical Centers.

(c) Institutional Payers must register only once. A Registered Payer is automatically registered for the next Fiscal Year.

(4) Billing Process for Institutional Payers.

(a) Each Hospital and Ambulatory Surgical Center shall send a bill for the Uncompensated Care Pool surcharge to Surcharge Payers, as required by c.118G, s.18A (b). Hospitals and Ambulatory Surgical Centers shall send this bill to Surcharge Payers from whom they have received payment for services in the most recent four quarters for which data is available. The bill will state the Surcharge Percentage. Hospitals and Ambulatory Surgical Centers shall send this bill to payers before September 1 of each Fiscal Year and before the effective date of any Surcharge Percentage.

(b) Each Hospital and Ambulatory Surgical Center shall also send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers who have not registered with the Division pursuant to 114.6 CMR 11.06(3)(a) and from whom they have received payment. The bill must be sent within 30 days of receiving the payment from the unregistered payer. The bill shall state the Surcharge Percentage, but not the dollar amount owed, and shall include notification of the surcharge payment process set forth below, as well as a registration form specified by the Division. Until the Hospital or Ambulatory Surgical Center receives the Registered Payer List, it shall send a bill for the surcharge at the same time as the bill for services provided to Institutional Payers which it did not already bill pursuant to 114.6 CMR 11.06(4)(a).

(5) Payment process for Institutional Payers

(a) Monthly Surcharge Liability. After the end of each calendar month, each Institutional Payer shall determine the surcharge amount it owes to the Pool for that month. The amount owed is the product of the amount of payments subject to surcharge, as defined in 114.6 CMR 11.02, by the Surcharge Percentage in effect during that month. The Institutional Payer may adjust the surcharge amount owed for any surcharge over- or under-payments in a previous period.

1. Institutional Payers that pay a global fee or capitation for services that include Hospital or ambulatory surgical services, as well as other services not subject to the surcharge, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by Hospitals or Ambulatory Surgical Centers. Such Institutional Payers must file this allocation method by October 1 of each fiscal year. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the Institutional Payer must file the new method with the Division before the new payment arrangement takes effect. Institutional Payers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

a. The Division will review allocation plans within 90 days of receipt. During this review period the Division may require an

Institutional Payer to submit supporting documentation or to make changes in this allocation method if it finds that the method does not reasonably allocate the portion of the global payment or capitation intended to be used for services provided by Hospitals or Ambulatory Surgical Centers.

b. An Institutional Payer must include the portion of the global payment or capitation intended to be used for services provided by Hospitals or Ambulatory Surgical Centers, as determined by this allocation method, in its determination of payments subject to surcharge.

2. An Institutional Payer must include all payments made as a result of settlements, judgments or audits in its determination of payments subject to surcharge. An Institutional Payer may include payments made by Massachusetts Hospitals or Ambulatory Surgical Centers to the Institutional Payer as a result of settlements, judgments or audits as a credit in its determination of payments subject to surcharge.

(b) Monthly Payments. Institutional Payers shall make payments to the Pool monthly. Each Institutional Payer shall remit the surcharge amount it owes to the Pool, determined pursuant to 114.6 CMR 11.06(5)(b), to the Division for deposit in the Pool. Institutional Payers shall remit the surcharge payment by the first business day of the second month following the month for which the surcharge amount was determined. For example, surcharge payments based on payments made to Hospitals and Ambulatory Surgical Centers in January are due to the Pool on March 1.

(c) Biannual Surcharge Payment Option.

1. Eligible Surcharge Payers. The Division will review each registered Surcharge Payer's payment history to determine if it is eligible for this option. In order to qualify, the Surcharge Payer must:

a. have remitted required surcharge payments and submitted all monthly coupons and the Surcharge Verification Form for the period January, 1998 through June, 1999; and

b. have reported payments less than $10,000 in the Surcharge Verification Form.

2. Ambulatory Surgical Centers, that are required to remit monthly surcharge payments due from self payers, may be eligible if they meet the criteria listed above. Hospitals must continue to file monthly notices.

3. The Division will notify payers eligible for the biannual option. The Payer may elect to receive biannual surcharge notices or to continue to receive monthly notices. Each biannual surcharge payments will equal (1) the appropriate surcharge percentage times (2) payments made to Massachusetts hospitals and ambulatory surgical centers for the prior six months.

(d) All surcharge payments must be payable in United States dollars and drawn on a United States bank. The Division will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) Any Institutional Payer, except Third Party Administrators, that has a surcharge liability of less than five dollars in any month or biannual payment period may delay payment until its surcharge liability is at least five dollars. For example, XYZ Company's surcharge liability for July is $3.50 and its liability

for August is $2.00. XYZ Company may delay payment in July but must remit a check for $5.50 in August.

(6) Payment process for Individual Payers (Self-pay). There is a surcharge on certain payments made by Individual Payers to Hospitals and Ambulatory Surgical Centers.

(a) Billing.

1. Hospitals and Ambulatory Surgical Centers shall include the surcharge amount on all bills to Individual Payers unless:

a. the patient's liability is less than the individual payment threshold determined by the Division. The individual payment threshold is a payment of $10,000 or more.

b. the patient is a non-Massachusetts resident for which the Hospital or Ambulatory Surgical Center can verify that the patient's family income would otherwise qualify the patient as a Low Income Patient under 114.6 CMR 12.03

c. the patient is approved for Medical Hardship in accordance with the requirements of 114.6 CMR 12.05. The bill shall direct Individual Payers to pay the surcharge to the Hospital or Ambulatory Surgical Center when making payment for services.

2. The amount of the surcharge billed is the product of (a) the patient's liability to the Hospital or Ambulatory Surgical Center, and (b) the Surcharge Percentage in effect on the billing date.

3. The amount of the surcharge owed by an Individual Payer is the product of (a) the total amount paid by the individual to a Hospital or Ambulatory Surgical Center; and (b) the Surcharge Percentage in effect on the payment date. Payments greater than or equal to the threshold received by Hospitals and Ambulatory Surgical Centers from Individual Surcharge Payers are subject to the surcharge.

(b) Hospitals and Ambulatory Surgical Centers must remit to the Division the surcharge amount owed by Individual Payers for every payment greater than or equal to the threshold made by Individual Payers. If an Individual Payer makes separate payments over a twelve month period that are equal to or greater than the threshold and relate to an outpatient visit or inpatient stay, the surcharge amount due applies to the aggregate amount paid for the outpatient visit or inpatient stay. The first surcharge payment is due to the Division when the total Individual Payer payment amount reaches the threshold.

(c) Hospitals and Ambulatory Surgical Centers shall remit such surcharge payments by the first business day of the second month following the month during which the surcharge was received. For example, surcharge payments received by Hospitals and Ambulatory Surgical Centers in January are due to the Pool on March 1. Hospitals and Ambulatory Surgical Centers may deduct collection agency fees for the collection of surcharge payments from Individual Payers from the total amount of surcharge payments forwarded to the Pool.

(d) All payments must be payable in United States dollars and drawn on a United States bank. The Division will assess a $30 penalty on any Surcharge Payer whose check is returned for insufficient funds.

(e) If an embassy of a foreign government pays a hospital or ambulatory surgical center bill on behalf of an individual, the provider may either: (a) bill the embassy for the individual's surcharge according to the billing and payment process for individual payers set forth in 114.6 CMR 11.06(6) or (b) bill the

embassy according to the billing process for Institutional Payers as set forth in 114.6 CMR 11.06(4). If the provider chooses to bill the embassy as an Institutional Payer and the embassy is not listed on the Registered Payer List, the provider shall include the embassy on the Unmatched Payer Report and send surcharge payer registration information to the embassy.

(7) Penalties.

(a) If a Hospital, Ambulatory Surgical Center, or Surcharge Payer fails to forward surcharge payments pursuant to 114.1 CMR 11.06, the Division shall impose an additional 1.5% interest penalty on the outstanding balance. The interest shall be calculated from the due date. For each month a payment remains delinquent, an additional 1.5% penalty shall accrue against the outstanding balance, including prior penalties.

1. The Division will credit partial payments first to the current outstanding liability, and second to the amount of the penalties.
2. The Division may reduce the penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the entity's payment history, financial situation, and relative share of the payments to the Uncompensated Care Pool.

(b) The Division may deny reimbursement for Eligible Services to any Hospital that fails to remit surcharge payments as required by 114.6 CMR 11.06(4)(b) until such Hospital remits the required amounts. The Division will notify such Hospital of its intention to withhold reimbursement.

(8) Administrative Review. The Division may conduct an administrative review of surcharge payments at any time.

(a) The Division will review data submitted by Hospitals, Ambulatory Surgical Centers, and Institutional Payers pursuant to 114. CMR 11.03, the Uncompensated Care Pool Surcharge Payer Registration forms submitted by Institutional Payers pursuant to 114.6 CMR 11.06(3)(a), and any other pertinent data. All information provided by, or required from, any Surcharge Payer, pursuant to 114.6 CMR 11.00 shall be subject to audit by the Division. For surcharge payments based upon a global fee or capitation allocated according to an allocation method accepted by the Division pursuant to 11.06(5)(a)1, the Division's review will be limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(b) The Division may require the Surcharge Payer to submit additional documentation reconciling the data it submitted with data received from Hospitals.

(c) If the Division determines through its review that a Surcharge Payer's payment to the Pool was materially incorrect, the Division may require a payment adjustment. Payment adjustments shall be subject to interest penalties and late fee, pursuant to 114.6 CMR 11.06(7), from the date the original payment was owed to the Pool. Payment adjustments may also be offset from Division of Medical Assistance payments, pursuant to 114.6 CMR 11.08(1).

(d) Processing of Payment Adjustments.

1. Notification. The Division shall notify a Surcharge Payer of its proposed adjustments. The notification shall be in writing and shall contain a

complete listing of all proposed adjustments, as well as the Division's explanation for each adjustment.

2. Objection Process. If a Surcharge Payer wishes to object to a Division proposed adjustment contained in the notification letter, it must do so in writing, within 15 business days of the mailing of the notification letter. The Surcharge Payer may request an extension of this period for cause. The written objection must, at a minimum, contain:

a. each adjustment to which the Surcharge Payer is objecting,
b. the Fiscal Year for each disputed adjustment,
c. the specific reason for each objection, and
d. all documentation that supports the Surcharge Payer's position.

3. Upon review of the Surcharge Payer's objections, the Division shall notify the Surcharge Payer of its determination in writing. If the Division disagrees with the Surcharge Payer's objections, in whole or in part, the Division shall provide the Surcharge Payer with an explanation of its reasoning.

4. The Surcharge Payer may request a conference on objections after receiving the Division's explanation of reasons. The Division will schedule such conference on objections only when it believes that further articulation of the Surcharge Payer's position is beneficial to the resolution of the disputed adjustments.

(e). Payment of Adjustment Amounts. Adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Notification letter. If the Surcharge Payer submitted a written objection, then adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Division's determination. The Division may establish a payment schedule for adjustment amounts.

11.07 Payments to Hospitals.

(1) Gross Liability to Hospitals. The Division will determine each Hospital's FY 2007 Total Payment for Low Income Patients pursuant to the provisions of St. 2006, c. 58, § 124. The Division will determine each hospitals FY 2007 Projected Low Income Patient Care Costs pursuant to 114.6 CMR 11.07(2) and determine each hospital's FY 2007 Total Payment for Low Income Patients pursuant to 114.6 CMR 11.07(3).

(2) FY 2007 Projected Low Income Patient Care Costs. The Division will calculate each hospital's FY 2007 Projected Low Income Patient Care Costs as follows:

(a) Base Period Low Income Patient Care Costs. The Division will determine each hospital's Base Period Low Income Patient Care Costs for the twelve month period from May 1, 2005, to April 30, 2006, using each hospital's reported free care charges from the UC Form times its most recent cost to charge ratio.

(b) Adjustments to Base Period Costs. The Division will adjust each hospital's Base Period Costs to account for projected changes in Uncompensated Care Pool demand, including required compliance with the Critical Access provision; MassHealth coverage for outlier days restored effective October 1, 2005; MassHealth Essential and SCHIP expansion effective July 1, 2006; projected enrollment in Commonwealth Care; and the impact of the citizenship

documentation requirement effective July 1, 2006. The Division will make adjustments to each hospital's base period costs as follows:

1. Critical Access Services. For each hospital that is not exempt from the Critical Access Services provision of 114.6 CMR 12.00 because there is a community health center within 5 miles driving distance of the hospital campus, the Division will calculate a Critical Access Services adjustment. For each hospital, the Division will determine the costs for all services coded as APG-44 "Well Care, Administrative" as reported by the hospital in its electronic claims for each month of the Base Period.

2. Outlier Day Restoration. For each hospital, the Division will calculate an Outlier Day Restoration adjustment by calculating total Low Income Patient Care Costs for MassHealth members, excluding MassHealth Limited members, for the portions of each hospital stay that exceeded 21 days as reported in the electronic claims for each month of the Base Period prior to the restoration of MassHealth coverage.

3. SCHIP Expansion. For each hospital, the Division will calculate a SCHIP Expansion adjustment by determining the total costs for services provided to children aged 18 and under that are Low Income Patients with a valid SSN as reported in its electronic claims for each month of the Base Period. The Division will multiply this amount by 99.4%, to reflect the percentage of Low Income Patient Care costs for children between 0 - 300% FPL group to total Low Income Patient Care Costs for all children between 0-400% FPL.

4. MassHealth Essential Expansion. For each hospital, the Division will calculate a MassHealth Essential Expansion adjustment as follows:

a. The Division will review all hospitals' Low Income Patient claims to identify claims for individuals <100% FPL. The Division will determine the costs associated with these claims. The Division will calculate an average per individual per month cost by dividing the total costs by the total number of such individuals.

b. The Division will estimate the total cost associated with MassHealth Essential wait list members by multiplying the average per individual per month cost by the number of individuals on the MassHealth wait list during the base period.

c. The Division will allocate the total cost to each hospital by determining each hospital's percentage of total UCP claims for MassHealth Essential members to total UCP claims for all MassHealth Essential members in the base period.

5. Preliminary Adjusted Base Year Costs. The Division will calculate each hospital's preliminary adjusted base year costs by (1) summing the adjustments calculated in 114.6 CMR 11.07 (2) (b) 1- 4; (2) dividing this sum by total costs reported in electronic claims submitted for the base period; and (3) applying this percentage to the hospital's Base Period Low Income Patient Care Costs determined pursuant to 114.6 CMR 11.07(1) (a) based on its UC Forms and deducting the resulting amount.

6. Commonwealth Care Enrollment. The Division will calculate a Commonwealth Care Enrollment adjustment for each hospital as follows:

a. The Division will add each hospital's (1) total base period Low Income Patient Care costs for individuals with income between 0-100% of the FPL and a reported SSN and (2) 50% of each hospital's base period Low Income Patient Care costs for all individuals with income between 0-100% of the FPL and no valid or reported SSN.

b. The Division will multiply this amount by 75% to reflect the projected enrollment rate for Commonwealth Care eligible individuals. The Division will multiply the product by an additional 42% to account for the projected enrollment of one twelfth of the eligible Low Income Patient population in Commonwealth Care in each month effective November 1, 2006.

7. Citizenship Documentation Requirement. The Division will calculate an adjustment to reflect the projected impact on UCP demand resulting from citizen documentation requirement as follows:

a. The Division will estimate the number of MassHealth members that will be required to document citizenship each month, assuming that MassHealth will redetermine eligilibility for one twelfth of its members each month, and that 20% of those redetermined will be terminated from MassHealth due to lack of citizenship documentation. The Division will multiply this number of individuals by the average cost per UCP user per month to determine the projected costs to the UCP that will result from MassHealth terminations for failure to document citizenship.

b. The Division will estimate the number of Low Income Patients that will be required to document citizenship each month, assuming that MassHealth will redetermine eligibility for one twelfth of such patients each month, and a percentage of those redetermined will be terminated from Low Income Patient status due to lack of citizenship documentation. The Division will multiply this number of individuals by the average cost per UCP user per month to determine the projected decrease in pool demand due to the new citizenship requirement.

c. The sum of these two calculations is the projected impact of the citizenship documentation adjustment. The Division will allocate this amount to each hospital based on its percentage of Low Income Patient Care Costs to Total Low Income Patient Care Costs.

8. Adjusted Base Period Costs. The Division will calculate each hospital's final Adjusted Base Period Costs by (1) subtracting the adjustments calculated in 114.6 CMR 11.07 (2) (b)6 and adding the adjustment calculated in 114.6 CMR 11.07 (2) (b)7 ; (2) dividing this sum by total costs reported in electronic claims submitted for the base period. The Division will apply this percentage to the hospital's adjusted base period low income patient care costs calculated pursuant to 114.6 CMR 11.07 (2)(b)(5) and will adjust the base period costs to reflect this amount.

(c) Disproportionate Share Hospitals. The Division will determine the two Safety Net Disproportionate Share Hospitals with the highest relative volume of

low income patient care costs and the fourteen Other Disproportionate Share Hospitals with the next highest relative volume of low income patient care costs by (1) calculating each hospital's FY 2004 uncompensated care costs by multiplying its reported FY 2004 uncompensated care charges by its Cost to Charge Ratio and (2) ranking each hospital by its ratio of uncompensated care costs to total statewide uncompensated care costs.

(d) Trend Factor. The Division will apply a Trend Factor to each hospital's Adjusted Base Period Costs.

1. For the two Safety Net Disproportionate Share Hospitals, the Division will apply a Trend Factor of zero.

2. For each Other Disproportionate Share Hospital, the Division will compare average charges for Low Income Patients and Emergency Room Bad Debt reported on its UC Forms for the first nine months of the Base Period and the last three months of the Base Period. The Division will average charges for all hospitals for both periods. If the Division determines that the average charges for the last three months exceed its average charges for the first nine months by 5% or more, the Division will apply a Trend Factor of 17.44%. For all other Hospitals, the Division will apply a Trend Factor of 5.96%.

4. For all Hospitals that are not Disproportionate Share Hospitals or Teaching Hospitals, the Division will apply a Trend Factor of 14.18%.

5. For all Teaching Hospitals that are not Disproportionate Share Hospitals, the Division will apply a Trend Factor of zero.

(e) The product of each hospital's Adjusted Base Period Costs and the applicable Trend Factor is the hospital's FY 2007 Projected Low Income Patient Care Costs.

(3) FY 2007 Total Payment for Low Income Patients.

(a) Determination of Payment Amount.

1. Calculation of Available Revenue. The Division will determine available revenue by deducting from total revenue (1) the special payment made to the two Safety Net Hospitals with the highest relative volume of Allowable Patient Care Costs in FY 2004 and (2) the payment adjustment of $5.79M to freestanding pediatric hospitals.

2. Payments to Disproportionate Share Hospitals. FY 2007 Total Payments for Low Income Patients include all payments from the Uncompensated Care Trust Fund, including offset payments. The FY 2007 Total Payment is the greater of (1) 90% of its total FY2006 payments from the Uncompensated Care Trust Fund, including payments for Eligible Services and all offset payments, or (2) 100% of its FY 2007 Projected Low Income Patient Care Costs.

3. Payments to Other Hospitals. For all other hospitals, the Division will determine the FY 2007 total Payment as follows:

a. Determine the ratio of (1) revenue available for payments to all other hospitals to (2) Total Allowable Low Income Patient Care Costs for all other hospitals;

b. Apply this ratio to each hospital's FY 2007 Projected Low Income Patient Care Costs to determine the hospital's FY 2007 Total Payment for Low Income Patients.

4. Mid Year Review. The Division will monitor enrollment in Commonwealth Care and the impact of such enrollment in projected Uncompensated Care Pool demand. The Division may adjust each hospital's payment to reflect change in demand as a result of Commonwealth Care enrollment.

(b) Method of Payment. The Division may make payment of each Hospital's Total Payment for Low Income Patients through a safety net care payment under the Massachusetts 1115 Demonstration waiver, a MassHealth supplemental hospital rate payment, or a combination thereof. The Division may limit a Hospital's Payment for Low Income Patients to comply with Federal Upper Payment Limits, limits and requirements under the Massachusetts Section 1115 Demonstration governing safety net care, or any other federally required limit on payments under 42 U.S.C. § 1396a(a)13 or 42 C.F.R. Part 447.

(4) Calculation of the Cost to Charge Ratio. The Division shall calculate a Cost to Charge Ratio for each Hospital. The Cost to Charge Ratio is the sum of each Hospital's inpatient reasonable costs and actual outpatient costs, divided by the Hospital's Gross Patient Service Revenues.

(a) Data Sources. The Division will obtain cost and charge information, including capital cost, malpractice data and organ acquisition costs, from the DHCFP-403 Report. The Division will review the DHCFP-403 Cost Report to ensure that the costs and Charges reported on the DHCFP-403 Report reconcile with those reported on audited financial statements, and are true, accurate, and complete.
For purposes of calculating case-mix indices, the Division will use the merged billing and case-mix information filed pursuant to 114.1 CMR 17.00.

(b) Fiscal Years through FY 2003.

1. The Division will calculate a preliminary Cost to Charge Ratio before the beginning of each Fiscal Year, utilizing data from two years prior to the rate year.
2. The Division will calculate an interim Cost to Charge Ratio midway through the Fiscal Year when year end financial data from the prior Fiscal Year becomes available.
3. The Division will calculate a final Cost to Charge Ratio after the end of the Fiscal Year when final audited financial data for the rate year becomes available.

(c) Reasonable Inpatient Costs. The Division will determine reasonable inpatient costs by summing the Hospital's reasonable comparable costs, reasonable capital cost, direct medical education cost, malpractice cost, organ acquisition cost, Hospital-based physician salaries, and adjustments for inpatient free care provided by physicians and undocumentable free care, if applicable. The calculation is as follows:

Reasonable Inpatient Costs =

Reasonable comparable costs
+ Reasonable capital expense
+ Direct medical education expense
+ Malpractice expense
+ Organ acquisition expense
+ Hospital-based physician salaries

+ Adjustment for inpatient free care provided by physicians, if applicable
+ Adjustment for undocumentable free care, if applicable

The calculation of reasonable comparable costs is set forth in 114.6 CMR 11.07(4)(c)1.
The calculation of reasonable capital expense is set forth in 114.6 CMR 11.07(4)(c)2.
The adjustment for inpatient free care provided by physicians is set forth in 114.6 CMR 11.07(4)(c)3. The adjustment for undocumentable free care is set forth in 114.6 CMR 11.07(4)(c)4.

1. Reasonable Comparable Costs. The Division will use an efficiency standard to determine reasonable comparable costs. Reasonable comparable costs equal the efficiency standard for Hospitals whose inpatient costs exceed the efficiency standard described below. Reasonable costs will equal actual costs for Hospitals whose costs do not exceed the efficiency standard. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will not be subject to the efficiency standard. The Division will calculate the efficiency standard as follows:

a. First, the Division will determine comparable costs by subtracting non-comparable costs from total inpatient costs. Non-comparable costs are: capital, direct medical education, malpractice, organ acquisition costs, and Hospital-based physician salaries. The methodology and specific data sources used to calculate these non-comparable costs will be distributed to Hospitals.

Comparable costs = Total inpatient costs
- Capital cost
- Direct Medical education cost
- Malpractice cost
- Organ acquisition cost
- Hospital-based physician salaries

b. Second, the Division will determine comparable costs per discharge by dividing the comparable costs by total discharges.

$$\text{Comparable cost per discharge} = \frac{\text{total comparable costs}}{\text{total discharges}}$$

c. Third, the Division will adjust the comparable cost per discharge for case mix and wage area. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken. The wage area indices will be those calculated by the Health Care Financing Administration (HCFA), and will be applied only to the labor portion of costs, also as determined by the Health Care Financing Administration. In Pool FY 1999 and forward, the wage area indices will be those calculated pursuant to 114.1 CMR 36.05(2)(c).

Standardized cost per discharge = Comparable cost per discharge

/ case mix index
/ wage area index

d. Fourth, the Division will calculate the mean standardized cost per discharge for all Hospitals weighted by the number of discharges in each Hospital. Specialty Hospitals, Sole Community Hospitals, and Public Service Hospitals will be excluded from this calculation. The statewide mean standardized cost per discharge is the efficiency standard.

e. Fifth, the Division will compare each Hospital's standardized cost per discharge to the efficiency standard.

i. For Hospitals whose own standardized cost per discharge is greater than the efficiency standard, the Division will calculate reasonable comparable costs as follows. First, the Division will adjust the efficiency standard for wage area and case-mix. The wage area index will be applied only to the labor portion of costs, as determined by the Health Care Financing Administration. Second, the Division will multiply these reasonable adjusted costs per discharge by total discharges to determine reasonable comparable costs.

Reasonable adjusted cost per discharge =
Efficiency standard
x wage area index
x case mix index

Reasonable comparable costs =
Reasonable adj. cost per discharge
x total discharges

(ii) For Hospitals whose standardized cost per discharge is less than the efficiency standard, and for Specialty Hospitals, Sole Community Hospitals and Public Service Hospitals, the Division will determine that reasonable comparable costs are equal to actual comparable costs as calculated in 114.6 CMR 11.07(4)(c)1a.

2. Reasonable inpatient capital costs. Inpatient capital costs will be held to reasonable limit. The Division will determine reasonable inpatient capital costs as follows:

a. The Division will calculate inpatient capital costs per discharge by dividing total capital costs allocated to inpatient by total discharges.

b. The Division will adjust inpatient capital costs per discharge for case mix. The case-mix index will be calculated using the AP-DRG Grouper (the New York State Grouper) and New York weights. The Grouper version used will be appropriate for the ICD-9-CM diagnosis and procedure codes of the year from which the financial data is taken.

c. The Division will determine the case-mix adjusted capital costs limit (CMCCL) by first sorting acute care Hospital's adjusted costs

in ascending order, and then producing a cumulative frequency of discharges. The CMCCL is established at the case-mix adjusted capital cost per discharge corresponding to the median discharge for the FY93 cost to charge calculation, and multiplied by an inflation factor. Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals will be excluded from this calculation.

d. Each Hospital's case-mix adjusted capital cost per discharge determined in 114.6 CMR 11.07(4)(c)2b is then compared to the case-mix adjusted capital costs limit (CMCCL) calculated in 114.6 CMR 11.07(4)(c)2c.

e. For Hospitals whose case-mix adjusted capital cost per discharge is less than or equal to the CMCCL, reasonable capital cost per discharge is equal to the Hospital's actual adjusted capital cost per discharge multiplied by the Hospital's case-mix index. For Hospitals whose case-mix adjusted capital cost per discharge is greater than the CMCCL, the reasonable capital cost per discharge is equal to the product of (a) the CMCCL, and (b) the Hospital's case-mix index.

f. The Division will determine reasonable inpatient capital costs by multiplying the reasonable capital cost per discharge calculated in 114.6 CMR 11.07(4)(c)2.e. by total discharges.
For Sole Community Hospitals, Specialty Hospitals, and Public Service Hospitals, reasonable inpatient capital costs equal actual inpatient capital costs.

3. Allowance for free care Provided by Physicians. The Division will increase the reasonable costs of qualifying Disproportionate Share Hospitals to include an allowance for free care provided by physicians.

a. The Division will allocate $2,500,000 for this allowance.

b. Hospitals will qualify for the allowance for free care provided by physicians if they qualify for the High Public Payer Hospital Disproportionate Share Adjustment pursuant to 114.1 CMR 36.07(2).

c. The Division will determine Allowable Patient Care Costs pursuant to 114.1 CMR 36.07(2). For the final Cost to Charge Ratio Calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the rate year consistent with the Cost to Charge Ratio being processed. For preliminary and interim Cost to Charge Ratio calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the latest available year.

d. The Division will then determine the sum of the amounts determined pursuant to 114.6 CMR 11.07(4)(c)3e for all Hospitals that qualify for an allowance for free care provided by physicians.

e. Each Hospital's allowance for free care provided by physicians is equal to $2,500,000 times the ratio of the Hospital's Allowable Free Care Costs determined in 114.6 CMR 11.07(4)(c)3c to the

total Allowable Free Care Costs of all qualifying Hospitals determined in 114.6 CMR 11.07(4)(c)3d.

f. The Division will increase the reasonable costs of eligible Hospitals by 'grossing up" the allowance to the level of total costs. The Division will divide the allowance for each Hospital pursuant to 114.6 CMR 11.04(3)(c)3e by the ratio of allowable Free Care Charges to total Charges pursuant to 114.6 CMR 11.04(3)(c)3c. The resulting amount will be added to total reasonable costs for the Hospital.

g. The Division will complete this calculation before the beginning of the Fiscal Year.

h. A Hospital that receives an allowance for the cost of free care provided by physicians must use the portion of Uncompensated Care Pool payments attributable to such allowance to reimburse such physicians for such Free Care .

4. Allowance for Undocumentable Free Care. The Division will increase the reasonable costs of qualifying Disproportionate Share Hospitals to include an allowance for undocumentable Free Care. This allowance is intended to contribute toward reimbursing Hospitals for Eligible Services provided to patients who are incapable of providing documentation of their status as Low Income Patients, but are patients who the Hospital has strong reason to believe would qualify as Low Income Patients under 114.6 CMR 12.00.

a. The Division will allocate $1,000,000 for this allowance.

b. Hospital will qualify for the allowance for Undocumentable free care if they qualify for the High Public Payer Hospital Disproportionate Share Adjustment pursuant to 114.1 CMR 36.07(2).

c. The Division will determine Allowable Free Care Costs pursuant to 114.1 CMR 36.07(2). For the final Cost to Charge Ratio Calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the rate year consistent with the Cost to Charge Ratio being processed. For preliminary and interim Cost to Charge Ratio calculations, the Division will incorporate the methodology used to determine the High Public Payer Hospital Disproportionate Share Adjustment, pursuant to 114.1 CMR 36.07(2), for the latest available year.. The Division will then determine the sum of the amounts determined pursuant to 114.6 CMR 11.04(4)(c)4c for all Hospitals that qualify for an allowance for undocumentable free care.

e. Each Hospital's allowance for undocumentable free care is equal to $1,000,000 times the ratio of the Hospital's Allowable Free Care Costs determined in 114.6 CMR 11.04(4)(c)4c to the total Allowable Free Care Costs of all qualifying Hospitals determined in 114.6 CMR 11.04(4)(c)4d.

f. The Division will increase the reasonable costs of eligible Hospitals by "grossing up" the allowance to the level of total costs. The Division will divide the allowance for each Hospital pursuant

to 114.6 CMR 11.04(4)(c)4e by the ratio of allowable Free Care Charges to total Charges pursuant to 114.6 CMR 11.04(4)(c)4d. This amount will be added to total reasonable costs.

g. The Division will complete this calculation before the beginning of the Fiscal Year.

(4) Monthly Payments. The Division will calculate and process monthly Hospital payments. The Division will calculate each Hospital's gross assessment liability to the Pool and the Pool's liability to the Hospital and make payments to the Hospital on a net basis.

(a) Estimated Hospital Gross Liability for Assessment Payments to the Pool.. The Division will estimate the Hospital's annual gross liability for assessments to the Pool by multiplying its Private Sector Charges times the ratio of total Hospital liability to the Pool to total Private Sector Charges for all Hospitals. The Division will notify each Hospital of its calculations of estimated liability. If a Hospital does not report the data required to calculate the Hospital's payment, the Division may substitute the required data elements with relevant industry averages, prior year reports by the Hospital, or other appropriate data. Assessments are calculated on an estimated basis and are subject to final settlement based on actual reported Private Sector Charges and according to 114.6 CMR 11.05.

(b) The Division will make a monthly payment to each Hospital of one twelfth of its FY 2006 Total Payment for Low Income Patients. These are prospective payments and are not subject to final settlement.

(5) Final Settlements for Fiscal Years through FY 2003.

(a) General. There will be a final settlement between the Uncompensated Care Pool and a Hospital for each Fiscal Year through FY 2003. The Final Settlement will be calculated based upon the hospital's gross liability to the Pool as determined pursuant to 114.6 CMR 11.05, the Pool's gross liability to the Hospital as determined pursuant to 114.6 CMR 11.07(2), and the payments made to the Hospital during the Fiscal Year. If the difference is positive, the difference is the amount of the hospital's liability to the Pool. If the difference is negative, the difference is the amount of the Pool's liability to the Hospital.

(b) Calculation. The Final Settlement will occur upon completion of the relevant audit and calculations by the Division for that Fiscal Year. Final settlements for the years through FY 2003 will be determined using actual Private Sector Charges, final Cost to Charge Ratios and actual free care charges, adjusted for any audit findings; and will include interim payment reconciliations, special payments, and esti-mated payments to and from the Uncompensated Care Pool.

(c) The Division may use penalty and interest revenue collected pursuant to 114.6 CMR 11.07(6) to cover unpaid liabilities from the settlement year that the Division determines to be uncollectible, (2) payments to Community Health Centers, and (3) Shortfall Amounts for any fiscal year.

(d) The Division may adjust Pool calculations to reflect determinations made under eligibility and compliance audits pursuant to 114.6 CMR 12.00.

(6) Penalties

(a) If a Hospital does not pay its liability amount by the due date, the Division will assess a 1.5% penalty on the outstanding balance. The Division will

calculate the penalty from the due date. The Division will assess an additional 1.5% penalty against the outstanding balance and prior penalties for each month that a Hospital remains delinquent. The Division will credit partial payments from delinquent Hospitals to the current outstanding liability. If any amount remains, the Division will then credit it to the penalty amount.

(b) The Division may reduce a Hospital's penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the Hospital's payment history, financial situation, and relative share of the payments to the Uncompensated Care Pool.

(c) The Division may adjust the monthly payment of any hospital that fails to submit required data, including but not limited to, DHCFP-403 or case mix data. The hospital's payment will be reduced by 5% for each month the hospital fails to file the required data. Failure to file the required data for more than two consecutive years may lead to denial of payment for low income patients.

11.08 Payments to Community Health Centers

(1) For FY 2007, total revenue available from the Uncompensated Care Trust Fund to pay freestanding community health centers for Eligible Services is $56,000,000.

(2) The Division may make payment for services by Community Health Centers through a MassHealth supplemental payment.

(3) Individual Medical Visits. The payment for an Individual Medical Visit is $97.20.

(a) Services to Low Income Patients.

1. The Division will pay for the following services provided to Low Income Patients determined pursuant to 114.6 CMR 12.03(a) at a percentage of the Individual Medical Visit rate as listed below:

Physician	100%
Nurse Practitioner, Nurse Midwife or Physician Assistant	100%
Dentist	75%
Clinical Psychologist	50%
Licensed Social Worker	50%

2. The Division will pay for the following services provided on-site at the Community Health Center as listed below:

Ancillary Laboratory	25% of Charges
Ancillary Radiology	25% of Charges
Ancillary - Miscellaneous	25% of Charges

3. Payment to an eligible Community Health Center for prescribed drugs shall be 100% of AAC + $8.50 dispensing fee for all generic drugs, and 90% of AAC + $8.50 dispensing fee for all brand drugs, except for the following brand drugs, which shall be reimbursed at 95% of AAC + $8.50 dispensing fee: Abilify, Geodon, Risperdal, Seroquel, Zyprexa, Suboxone, insulin (ex. Humalog, Humelin, Lantus, Novalog, Novelin). In the event that a generic therapeutic treatment alternative to any of the

named drugs becomes available, payment for the respective drug shall revert to 90% of AAC + $8.50 dispensing fee

a. Conditions for Payment

i. The Community Health Center may bill only for prescribed drugs dispensed through its Community Health Center 340B Pharmacy; and

ii. The Community Health Center is only eligible for payment from the Uncompensated Care Pool for prescribed drugs if the Community Health Center is also providing prescribed drugs to MassHealth members and receiving payment from MassHealth according to 114.3 CMR 31.07; and

iii. The Community Health Center must submit a copy of the OPA email or letter of notification to the Division stating that it has met the registration requirements in the OPA database, prior to billing the Uncompensated Care Pool; and

iv. The Community Health Center may not submit a claim to the Uncompensated Care Pool for MassHealth patients for a drug for which Prior Approval is required and (1) Prior Approval was not requested or (2) Prior Approval was denied; and

v. The Community Health Center may not submit a claim for the unpaid co-pays or deductibles of low income patients; and

vi. The Community Health Center may not submit a claim for a drug that is excluded by MassHealth under the provisions of 130 CMR 406.413(B); and

vii. The Community Health Center may not submit a claim for a prescribed drug that does not appear on the MassHealth Drug list as defined in 130 CMR 406 unless the prescription has been approved by the Community Health Center's Pharmacy and Therapeutics Committee.

b. The Community Health Center may establish a patient co-pay policy for patients eligible to receive Uncompensated Care Pool assistance. Revenue from this policy shall be limited to covering the aggregate remaining reasonable costs attributable to the unreimbursed portion of the AAC plus unreimbursed dispensing costs exceeding the $8.50 dispensing fee.

(b) Patient Contribution. The Division will pay for services, in excess of the patient contribution, provided to Low Income patients who meet the criteria set forth in 114.6 CMR 12.03(3)(b) or Medical Hardship set forth in 114.6 CMR 12.05.

(4) Individual Dental Visit An Individual Dental Visit shall consist of two or fewer procedures as defined by 114.3 CMR 14.00. A payment of $20.36 will be made for each additional procedure completed during a single Individual Dental Visit. The Division will pay for dental services, in excess of the patient contribution, provided to Low Income patients who meet the criteria set forth in 114.6 CMR 12.03(3)(b) or Medical Hardship set forth in 114.6 CMR 12.05.

11.09 Special Provisions

(1) MassHealth payment offset for Hospitals and Surcharge Payers. If a Hospital or Surcharge Payer fails to make scheduled payments and maintains an outstanding obligation to the Pool for more than 45 days, the Division may notify MassHealth to offset payments on the claims of the Hospital or Surcharge Payer, or any entity under common ownership, as defined in 130 CMR 450.101, or any successor in interest to the Hospital or Surcharge Payer, in the amount of payment owed to the Uncompensated Care Pool, including accrued interest, penalties and late fee. Payments offset in accordance with this provision shall be credited to the Hospital's or Surcharge Payer's outstanding liability to the Pool.

(a) The Division shall notify the Hospital or Surcharge Payer in writing of the dollar amount to be offset from the Surcharge Payer's MassHealth claims. Such notification shall be sent to the Hospital or Surcharge Payer via certified mail at least ten days prior to notifying MassHealth.

(b) If a Hospital or Surcharge Payer believes the amount to be offset is incorrect because of an arithmetic, mechanical or clerical error, it may object in writing during this ten day period to the Division of Health Care Finance and Policy. The written objection must contain an explanation of the perceived error as well as documentation to support the Hospital's or Surcharge Payer's objection. Hospitals and Surcharge Payers may not appeal a payment offset to MassHealth.

(c) Upon review of the Hospital's or Surcharge Payer's objections, the Division shall notify the Hospital or Surcharge Payer of its determination in writing. If the Division disagrees with the Hospital's or Surcharge Payer's objections, in whole or in part, the Division shall provide the Surcharge Payer with an explanation of its reasoning.

(d) The Division shall notify MassHealth in writing of the dollar amount to be offset from the Hospital's or Surcharge Payer's MassHealth claims.

(e) Hospitals and Surcharge Payers to which payment is offset must serve all Title XIX recipients in accordance with the contract then in effect with MassHealth, or, in the case of a non-contracting Hospital or Disproportionate Share Hospital, in accordance with its obligation for providing services to Title XIX recipients pursuant to M.G.L. c. 118G.

(2) Financial Hardship. A Hospital or Surcharge Payer may request a deferment or partial payment schedule due to financial hardship.

(a) In order to qualify for such relief, the Hospital or Surcharge Payer must demonstrate that its ability to continue as a financially viable going concern will be seriously impaired if payments pursuant to 114.6 CMR 11.05 or 114.6 CMR 11.06 were made.

(b) If the Division finds that payments would be a financial hardship, the Division may, at its discretion, establish the terms of any deferment or partial payment plan deferment. The deferment or payment schedule may include an interest charge.

1. The interest rate used for the payment schedule shall not exceed the prime rate plus 2%. The prime rate used shall be the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.

2. A Surcharge Payer may make a full or partial payment of its outstanding liability at any time without penalty.

3. If a Surcharge Payer fails to meet the obligations of the payment schedule, the Division may assess penalties pursuant to 114.6 CMR 11.05.

(3) Severability. The provisions of 114.6 CMR 11.00 are severable. If any provision or the application of any provision to any Hospital, Community Health Center, surcharge payer or Ambulatory Surgical Center or circumstances is held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.60 CMR 11.00 or the application of such provisions to Hospitals, Community Health Centers or circumstances other than those held invalid.

(4) Administrative Information Bulletins. The Division may issue administrative information bulletins to clarify policies and understanding of substantive provisions of 114.6 CMR 11.00 and specify information and documentation necessary to implement 114.6 CMR 11.00.

REGULATORY AUTHORITY

114.6 CMR 11.00 M.G.L. c. 118G.